GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS,
SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS
237 Coliseum Drive
Macon, Georgia 31217-3858
(478) 207-2440 (Telephone) (866) 888-7130 (Fax)
www.sos.state.ga.us/plb/counselors

APPLICATION TO REACTIVATE LICENSE

Check applicable license:
- ❒ Clinical Social Worker
- ❒ Licensed Master Social Worker
- ❒ Marriage and Family Therapist
- ❒ Licensed Professional Counselor

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED.**

- Please type or print legibly.
- Your Application to Reactivate must be **complete** with all required information, documentation and fee before it will be reviewed by the Board.
- Attach documentation of Continuing Education hours, accrued according to Board Rule Chapter 135-9-.06 and 135-9-0.1. This documentation should include a description of the continuing education activities and photocopies, as outlined in Board Rule Chapter 135-9-.03
- See Fee Schedule for All Fees

LEGAL NAME: _____
Last First Middle Maiden

HOME ADDRESS:_____
Street (P.O. Box not acceptable) City State ZIP Code

MAILING ADDRESS IF
DIFFERENT THAN STREET ADDRESS: _____
Street , P.O. Box City State Zip Code

BUSINESS ADDRESS:_____
Street City State Zlp Code

Email Address: _____

_____ I am a U.S. citizen. _____ I am not a U.S. citizen, but am a qualified alien under the federal Immigration and Naturalization Act, and I am lawfully present in the United States.

CHECK PREFERRED MAILING ADDRESS: ❒ Home ❒ Business

DAYTIME PHONE: ( ) | OTHER PHONE: ( )

SOCIAL SECURITY NUMBER: _____

*This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. 19-11-1 and O.C.G.A. 20-3-295, 42 U.S.C.A. 551 and 20 U.S.C.A. 1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes.

_____ _____
Date Signature of Licensee/Applicant

Sworn to and subscribed before me this
_____day of _____, _____.

_____
Notary Public
My Commission Expires_____ NOTARY SEAL

OFFICE OF SECRETARY OF STATE

PROFESSIONAL LICENSING BOARDS DIVISION
GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS
237 Coliseum Drive
Macon, Georgia 31217
(478) 207-2440

CONSENT FORM

I authorize the **Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists** to conduct a background investigation of me to determine my suitability for licensure. I give my consent for full and complete disclosure of all records and information concerning myself to the Board, their authorized representatives, or any other persons deemed necessary by the Board in determining my suitability, whether such records and information are of a public, private, or confidential nature, to include criminal history records. This authorization will remain in effect for the duration of my active licensure status with this state or until cancelled by me in writing.

_____

Applicant's Full Name (Printed)

_____

_____

Physical Address (P.O. Boxes **NOT** Accepted)

_____ _____ _____ _____

Sex Race Date of Birth Social Security Number

Place of Birth (City/State): _____

Aliases or Maiden Name: _____

_____ _____

(Signature of Applicant) (Date)